

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 17 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10582
State File No.

Registration District No. 153

Primary Registration District No. 5219 4087

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Freeman Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether)
In this community ✓
years, months or days 65

8. (a) PRINT FULL NAME Sarah E. Horan

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife John Horan 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased April 11-1848
(Month) (Day) (Year)

8. AGE: Years ✓ Months 11 Days 9 If less than one day hr. 0 min.

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER { 12. Name Samuel Hearell
13. Birthplace Dont know (City, town, or county) (State or foreign country)
14. Maiden name Martha Miller
15. Birthplace Dont know (City, town, or county) (State or foreign country)

16. (a) Informant Rebecca Doran

(b) Address Freeman Mo

17. (a) Burial (b) Date thereof May 25-1940
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Freeman Mo

18. (a) Signature of funeral director HARRISONVILLE, MO.

(b) Address 3-24-40

19. (a) 3-24-40 (b) Mrs. Pearl Suddarth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Freeman Mo
(If outside city or town limits, write "RURAL")
(d) Street No. ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 23
year 1940 hour ✓ minute ✓ M.

21. I hereby certify that I attended the deceased from 2-4- 1940 to 3-23- 1940
that I last saw her alive on 3-20- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death General Cardiac & Circulatory Insufficiency Duration
Fracture of Right Hip
Due to from a fall
Due to Seriously

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

28. Signature Harrisonville Mo (M. D. or other)
Address 3-24- Date signed 3-24-

1860
99

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10582

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 153

Primary Registration District No. 4089

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Cass
(b) City or town Freeman
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME Sarah E. Doran

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 11 9 h. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH Month mar day 23
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h. alive on and that death occurred on the date and hour stated above. Immediate cause of death General Cardiac Circulatory Insufficiency Duration

Due to fract. of hip from fall in the home
Due to at 5 am. on Feb 4 - 1940
Other conditions Got up to get a drink early in am while still dazed
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (r) Means of injury

23. Signature D B Lovett (M. D. or other) Harmonville
Address Harmonville Date signed

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10582

Registrar's No. 5

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 133

Primary Registration District No. 4087

1. PLACE OF DEATH:

- (a) County Cass
(b) City or town Freeman
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME Sarah E. Doran

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced and

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased apr 11 1849
(Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days 12 If less than one day min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 3-24-40 (b) Mrs. Pearl Suddarth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH Month mar day 23
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19
that last saw him alive on 19
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury

23. Signature D. S. Long (M, D. or other)
Address Harrisonville Date signed mo

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.